REQUEST FOR AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: _____

You have the right to request that the Department of Health Services account for the disclosures of personal information by the Cancer Detection Section. You are not entitled to an accounting of disclosures related to treatment, payment, or health care operations; when you have authorized the disclosure; or when the disclosure is to the Cancer Detection Section beneficiary's family, relatives, or others involved in the individuals care. You are also not entitled to an accounting of disclosures for National Security intelligence purposes or to law enforcement officials. You must send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You may also be required to send documentation verifying your address (see Page 3). Mail this completed form to:

Cancer Detection Section
Attention: HIPAA Manger
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413

INDIVIDUAL FOR WHOM YOU ARE REQUESTING AN ACCOUNTING OF DISCLOSURES		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
Cancer Detection Programs: Every Woman Counts RECIPIENT ID NUMBER*	DATE OF BIRTH:	SOCIAL SECURITY NUMBER*

*We use these numbers to make sure information goes only to appropriate persons.
If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION			
LAST NAME:		FIRST NAME:	MIDDLE INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
DAYTIME PHONE NUMBER ( ) _____	ALTERNATE PHONE NUMBER ( ) _____	BEST TIME TO REACH YOU	EMAIL ADDRESS

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST AN ACCOUNTING OF DISCLOSURES FOR THE INDIVIDUAL ABOVE?

- ☐ PARENT
- ☐ CONSERVATOR
- ☐ GUARDIAN
- ☐ EXECUTOR OF WILL
- ☐ MEDICAL POWER OF ATTORNEY
- ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL. EXECUTORS MUST ATTACH A DEATH CERTIFICATE.

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I REQUEST THAT THE DEPARTMENT OF HEALTH SERVICES ACCOUNT FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION.

FROM: _____(MONTH/YEAR) TO: _____(MONTH/YEAR)

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

REPRESENTATIVE SIGNATURE:_____DATE:_____

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 2 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.